STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125024	A. BUILDING: _____ B. WING _____	09/03/2019

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4 000	Initial Comments A re-licensure survey was conducted by the Office of Health Care Assurance (OHCA) on 08/26/19 - 09/03/19. The facility was found not to be in substantial compliance with Hawaii Administrative Rules, Chapter 11-94.1 During this survey, one facility reported incident (ACTS #7585) and two resident complaints (ACTS #7428, 7594) were investigated and unsubstantiated. However, one resident complaint (ACTS #7595) was investigated and substantiated. Survey Dates: 08/26/19 - 09/03/19 Survey Census: 70 Sample Size: 37 Supplemental Residents: 1	4 000		
4 099	11-94.1-22(a) Medical record system (a) The facility shall have available sufficient appropriately qualified staff and necessary supporting personnel to facilitate the accurate processing, auditing and analysis, indexing, filing, and prompt retrieval of records, record data, and resident health information. This Statute is not met as evidenced by: Based on record review and interview with staff member, the facility failed to transmit a discharge assessment within 14 days after completion. Findings include: A record review on the afternoon of 08/28/19 found Resident (R)1 was admitted to the facility on 04/04/19 and discharged home on 04/23/19. A review of the Minimum Data Set (MDS) found	4 099	Nuuanu Hale is committed to ensure that submittal of required information regarding resident status will be submitted on a timely basis. R1 a review was completed on 8/29/19 due to an inquiry received from Surveyor. It was identified that the discharge assessment was not transmitted as required. QA RN resubmitted	9/3/19

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4 099	Continued From page 1 the facility's software was populated with red Xs for finish, submit and accept of the discharge MDS. On 08/29/19 at 12:49 PM concurrent record review and interview was conducted with Director of Nursing (DON)1. The review confirmed the software documented red X for finish, submit and accept. DON1 reported the red Xs indicate the MDS was not done; however, the assessment was completed on 05/14/19 as indicated by the signature of the MDS Coordinator. DON1 was agreeable to follow up. On 08/29/19 at 01:08 PM, DON1 reported the review of the MDS submission and confirmation report found no confirmation R1's assessment was done. The DON reported that there may have been an error and the assessment was rejected. The facility will attempt to resubmit this assessment.	4 099	assessment at that time and it was successfully transmitted. The MDS Coordinator reviewed the current process for completion of discharge assessment and transmittal and it was determined that the process required amendments. (9/3/2019) To prevent this deficient practice from recurring the following has been implemented as the MDS Coordinator will: (9/3/2019 & ongoing) 1. Run the Next MDS Due report weekly, every Friday, on the EMR; 2. Review validation report on QIES and compare with MDS weekly schedule to verify transmittal status; 3. Run the CASPER Report (MDS 3.0 Missing OBRA assessment) on QIES monthly Ongoing monitoring and evaluation will be conducted by MDS Coordinator, QA RN and DON to ensure compliance with this requirement and discussed/addressed in quarterly QAPI/QAA as well as weekly Stand-up meetings as applicable. (9/3/2019 & ongoing)	
4 113	11-94.1-27(2) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon	4 113		10/8/19

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4 113	Continued From page 2 request. A facility must protect and promote the rights of each resident, including: (2) The right to be free of interference, coercion, discrimination, and reprisal from the facility that shall include the right to be free of chemical or physical restraints not medically indicated; This Statute is not met as evidenced by: Based on resident interview, record review, staff interview, the facility failed to provide one (Resident (R) 55) out of three residents reviewed, the right to be free from physical restraint; where R55's wheelchair was restrained to a wall railing, for the purpose of convenience, and not for the treatment of medical symptoms. Findings Include: During resident interview with another resident (R) 35 on 08/29/19 at 01:55 PM, R35 stated a couple weeks ago, witnessed R55 sitting in a wheelchair which was tied to a railing in the hallway near the nursing station. R35 stated that it prevented R55 from being able to "role" their wheelchair around. R35 stated the concern was brought up to the Social Worker (SW) 1 several days later. During staff interview with SW1 on 08/29/19 at 02:50 PM, SW1 was able to recall the following witnessed events discussed from R35: On 08/15/19, R55's wheelchair was tied to a railing. On 08/19/19, the concern was brought up to SW1. SW1 then reported the incident (in stand-up meeting) to facility administration. During an interview with the Administrator	4 113	Nuuanu Hale is committed to ensure that all violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident properly are reported to the State Agency and APS on a timely basis as required. R55 - On 8/19 /2019 another resident reported to the Social Services Designee that he had observed that R55□s wheelchair had been tied to railing during the morning meal on 8/15/19. SSD informed the IDT of this during that mornings Stand-Up meeting which is also used as a means to discuss resident issues/concerns and QA matters. At this time the IDT reviewed the facility□s protocol for investigation of incidences of Abuse, Neglect and Exploitation as well as the flowchart for reporting (Incident Reporting for Alleged Abuse). Based on review of resident diagnosis, status, interview of staff, it was determined that there was no actual or potential for harm or willful intent to cause harm to the resident on the part of the Staff involved. The DON interviewed the alleged perpetrator who indicated that the resident	

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4 113	Continued From page 3 (Admin) on 08/29/19 at 03:30 PM, Admin was able to recall the incident and stated that the facility had done and completed their investigation on 08/21/19. Record review revealed R55 was admitted on 03/25/15 with a diagnosis of dementia, history of falling, vitamin B deficiency, abnormal weight loss, hypothyroidism. A review of the most recent quarterly assessment with an Assessment Reference Date (ARD) of 07/19/19 showed a Brief Interview for Mental Status (BIMS) score of 01 which indicated severe cognitive impairment. A review of R55's progress notes showed the following: 08/05/19 Propels self along the hallway, transferred self back to bed, 08/02/19 pleasantly confused, combative, non-compliant, 08/01/19 can't stay sitting on her w/c for long period of time. Review of the care plan for R55 revealed the following: "Problem, Falls, at risk for falls d/t medical condition with diagnosis of Dementia, HTN, age-related osteoporosis, Anemia. Resident is not aware of ... safety and does not call for assistant. Approach, make sure everything ... is within reach at all times, frequent visual check, offer toileting q2hrs or as needed and when see res. heading to ... bedroom, follow resident and ask ... needs". A review of the event report/investigation revealed R55 had no physical injury, no signs of mental abuse, and no change in demeanor or behavior. R55 was taken to the toilet, but continued to wheel self around. R55's wheelchair was tied to the railing, for about five minutes, to allow finishing breakfast, then was released to watch TV.	4 113	was wheeling herself in and out of the elevator. Usually this behavior indicates that the resident needs to be toileted, so the alleged perpetrator toileted the resident; however, this did not stop the resident from wheeling herself around. As the alleged perpetrator was concerned about her history of weight loss and poor intake at times, he tied her wheelchair to the railing, to get her to remain in place and eat her breakfast. He stated that the wheelchair was tied for about 5 minutes, allowing the resident to finish breakfast, then was untied and wheeled to watch TV. The alleged perpetrator stated that he was watching the resident and that the resident was engaged in eating the entire time. Therefore, an OHCA event report was not completed. An action plan was developed with the alleged perpetrator being counseled by DON, retrained about Resident Rights, use of restraints and any disciplinary action to be taken. R55 □ review of Plan of Care was conducted and revised to ensure that situations of this nature does not recur and provision of alternative interventions to be utilized when resident moves about in wheelchair. (9/3/2019) Huddles were held with all staff regarding the use of restraints that are medically indicated, use of restraints that prevent the resident freedom of movement and also Resident Rights including Abuse, Neglect and Exploitation. A review of facility policy and procedure was conducted to ensure compliance with this requirement. (9/3-4/19)	

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4 113	Continued From page 4	4 113	Training of all staff will be conducted to ensure all are informed of the Plan of Correction, expectations of staff and any new or revised policies and procedures or protocols developed. (10/1-8/19) Annual training will continue to be provided to all staff regarding Resident Rights with review of ensuring that residents are free from Abuse, Neglect and Exploitation including the unnecessary use of restraints. (Annual(7/2020) & ongoing) Ongoing monitoring and evaluation will be conducted by SSD, QA RN and DON to ensure compliance with this requirement and discussed/addressed in quarterly QAPI/QAA as well as weekly Stand-up meetings as applicable. (9/3/2019 & ongoing)	
4 115	11-94.1-27(4) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility;	4 115		10/8/19

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4 115	Continued From page 5 This Statute is not met as evidenced by: Based on observations and interviews, the facility failed to promote dignity for two of 24 residents (R48, R222) included in the initial pool. Findings Include: 1) On 08/26/19 at 11:16 AM observed R48 being fed lunch outside of her room in the hallway. Initially, RN12 placed a spoonful of pureed food with rice into R48's mouth, but the resident did not continue to open her mouth. The RN12 then used a syringe to feed R48 and coaxed R48 to open her mouth. Using the tip of the syringe, RN12 attempted to insert food into R48's mouth on the left side. There were three other residents having lunch in the hallway, with a family member for one of those residents eating. Feeding R48 a pureed diet with a syringe in the hallway did not promote dignity while dining. 2) On 08/26/19 at 08:29 AM upon entering R222's room, observed R222 sitting on a bedside commode with R222's personal brief around the knees. The bedside commode was located between R222 and R3's bed. The privacy curtain separating the beds was open. Furthermore, R3 was in the room while R222 was utilizing the bedside commode. In addition, the window curtain and louvers were open, and the adjacent building was visible through the window. On 08/30/19 at 08:34 AM, a second observation found that R222 was within view of visitors to the adjacent building from the room window. A record review of the Minimum Data Set with	4 115	Nuuanu Hale is committed to ensure to ensure that all residents are treated in a manner and environment that promotes the rights of the resident. R48 □ a review of the resident□s plan of care was conducted and revised to indicate that feedings of resident when a syringe is used will be conducted in resident□s room to assure resident privacy. (9/3/2019) R222- a review was conducted of the resident□s comprehensive assessment and plan of care. Resident was admitted on 8/15/19 and assessed to require limited to extensive assistance and was coded on MDS at the highest level of assistance in ADLs. As resident is on QUEST only an initial MDS is required so when resident demonstrated improvement in ADLs due to therapies she received, by 8/19/19 resident supervision with limited assistance, no update of MDS was made. On 8/20/19 resident was occasionally independent during the day with limited to extensive assist in the evenings and at night. (9/3/2019) Review of resident□s care plan indicated that she had been advised to use her call light to call for assistance from staff however, as the resident became more independent, she was ambulating and going to commode on her own. Resident was discharged to home on 9/11/19.	

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4 115	Continued From page 6 Assessment Reference Date of 08/15/19 documented that R222 requires extensive assistance with one person physical assist for toilet use. Additionally, R222 is not steady and requires staff assistance while moving on and off the toilet.	4 115	Reviews and revisions of Plans of Care for residents with similar needs were completed as appropriate to ensure all residents dignity and privacy is maintained. (9/3-9/19) Huddles with all staff were conducted to ensure that resident dignity is maintained and to ensure that: (9/3-4/19) 1. All curtains are pulled to protect resident privacy during all care provision and as per resident's preference/choice. Staff to check resident rooms as they walk around unit and should they observe the privacy curtains not closed, staff shall close them. 2. When residents receive feedings via a syringe or tube or other means, feedings will be provided in the privacy of the resident's room to maintain residents dignity and privacy. Retraining of all staff on Resident's Rights was conducted to ensure that staff are aware of the importance of maintaining resident dignity. Annual and or more frequent training is also conducted as applicable. (9/4/2019) Training of all staff will be conducted to ensure all are informed of the Plan of Correction, expectations of staff and any new or revised policies and procedures or protocols developed. (10/1-8/19) Ongoing monitoring and evaluation will be conducted by SSD, QA RN and DON to ensure compliance with this requirement and discussed/addressed in quarterly QAPI/QAA as well as weekly Stand-up	

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4 115	Continued From page 7	4 115	meetings as applicable. (9/3/19 & ongoing)	
4 131	11-94.1-29(b) Resident abuse, neglect, and misappropriation (b) All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source or origin, and alleged misappropriation of resident property shall be reported immediately to the administrator of the facility, and to other officials in accordance with state law through established procedures. This Statute is not met as evidenced by: Based on record review, staff interview, and review of policy, the facility failed to report an allegation of abuse and/or the results of the abuse investigation to other officials (including the State Survey Agency) in accordance with State law through established procedures. Findings Include: Cross Reference F604, F610 During resident interview with another resident (R) 35 on 08/29/19 at 01:55 PM, R35 stated a couple weeks ago, witnessed R55 sitting in a wheelchair which was tied to a railing in the hallway near the nursing station. R35 stated that it prevented R55 from being able to "role" their wheelchair around. R35 stated the concern was brought up to the Social Worker (SW) 1 several days later. During staff interview with SW1 on 08/29/19 at	4 131	Nuuanu Hale is committed to ensure that all violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident properly are reported to the State Agency and APS on a timely basis as required. R55 - On 8/19 /2019 another resident reported to the Social Services Designee that he had observed that R55□s wheelchair had been tied to railing during the morning meal on 8/15/19. SSD informed the IDT of this during the morning Stand-Up meeting which is also used as a means to discuss resident issues/concerns and QA matters. At this time the IDT reviewed the facility□s protocol for investigation of incidences of Abuse, Neglect and Exploitation as well as the flowchart for reporting (Incident Reporting for Alleged Abuse).	9/3/19

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4 131	Continued From page 8 02:50 PM, SW1 was able to recall the following witnessed events discussed from R35: On 08/15/19, R55's wheelchair was tied to a railing. On 08/19/19, the concern was brought up to SW1. SW1 then reported the incident (in stand-up meeting) to facility administration. A review of the investigation report revealed the following: the possibility of abuse incident was identified, there was no reports of injury and/or changes to R55's demeanor, behavior, and cognition was discussed. During an interview with the Administrator (Admin) on 08/29/19 at 03:30 PM, Admin was able to recall the incident and stated that the facility had done and completed an investigation on 08/21/19. Admin acknowledged that the possibility of an abuse incident was identified. Admin also acknowledged that the facility had an in-depth discussion on the determination of actual or potential for harm. Thus, the facility determined that there was no actual harm, so an event report was not submitted to other officials (including the State Survey Agency). During a second interview with the Admin on 08/30/19 at 12:30 PM, Admin acknowledged that a potential for harm existed; thus, an allegation of abuse and/or results of an abuse investigation should have been reported to other officials (including the State Survey Agency). A review of facility policy titled Resident's Rights, Freedom from Abuse, Neglect, and Exploitation stated the following: Policy; Nuuanu Hale shall assure that all residents are fully aware of and able to exercise their rights during their stay at this facility and are treated by staff members, family members, friends, visitors and other	4 131	Based on review of resident diagnosis, status, interview of staff, it was determined that there was no actual or potential for harm or willful intent to cause harm to the resident on the part of the Staff involved. As the receipt of the report of the incident was five (5) days post the incident occurring, and per staff interviews, there was no visual physical injury to the resident, no signs of mental abuse and no change in the residents affect and demeanor, the IDT determined that a report to the Survey Agency was not required. Therefore, no report was submitted at that time. A review of the facility Policy and Procedure was conducted and also the process for incident investigation was conducted with IDT. Based on the review, a report to the State Agency was completed and submitted. (9/3/2019) To prevent this deficient practice from recurring, all incidences of allegation of abuse, neglect and exploitation of resident property will be submitted to the State Agency and APS to ensure compliance with this requirement, as applicable. (9/3/2019) Ongoing monitoring and evaluation will be conducted by IDT and Administrator to ensure compliance with this requirement and discussed/addressed in quarterly QAPI/QAA as well as weekly Stand-up meetings as applicable. (9/3/2019 & ongoing)	

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4 131	Continued From page 9 residents in accordance with the rights to which they are entitled under applicable Federal and State regulations. Procedure for Investigation of allegations of abuse, neglect, exploitation or mistreatment; An investigation is immediately conducted when there are allegations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property and shall be immediately reported. 1. Allegations that involve abuse or result in serious bodily injury shall be reported immediately, but not later than 2 hours after the allegation is made. 2. Allegations that do not involve abuse and do not result in serious bodily injury shall be reported no later than 24 hours. 3. The Administrator or designee shall be notified immediately, who will immediately initiate the reporting to the Office of Health Care Assurance, Adult Protective Services and/or the Department of Human Services via the required reporting forms for each respective agency and as per above time frames. 4. An initial report will be initiated with a final report submitted within 5 days. If the investigation is not able to be completed, an interim report shall be submitted providing the agencies with a revised time frame for submittal of final investigative report.	4 131		
4 133	11-94.1-29(d) Resident abuse, neglect, and misappropriation (d) The facility shall maintain a record that all alleged violations were thoroughly investigated, and shall take all reasonable steps to prevent further abuse while the investigation is in progress.	4 133		9/3/19

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4 133	Continued From page 10 This Statute is not met as evidenced by: Based on record review, staff interview, and review of policy, the facility failed to thoroughly investigate an allegation of abuse and/or report the results of the abuse investigation to other officials in accordance with State law, including the State Survey Agency, within 5 working days of the incident. Findings Include: Cross Reference F604, F609 During resident interview with another resident (R) 35 on 08/29/19 at 01:55 PM, R35 stated a couple weeks ago, witnessed R55 sitting in a wheelchair which was tied to a railing in the hallway near the nursing station. R35 stated that it prevented R55 from being able to "role" their wheelchair around. R35 stated the concern was brought up to the Social Worker (SW) 1 several days later. During staff interview with SW1 on 08/29/19 at 02:50 PM, SW1 was able to recall the following witnessed events discussed from R35: On 08/15/19, R55's wheelchair was tied to a railing. On 08/19/19, the concern was brought up to SW1. SW1 then reported the incident (in stand-up meeting) to facility administration. A review of the investigation report revealed the following: the possibility of abuse incident was identified, there was no reports of injury and/or changes to R55's demeanor, behavior, and cognition was discussed. During an interview with the Administrator (Admin) on 08/29/19 at 03:30 PM, Admin was able to recall the incident and stated that the	4 133	Nuuanu Hale is committed to ensure that all violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident properly are reported to the State Agency and APS on a timely basis as required. R55 - On 8/19 /2019 another resident reported to the Social Services Designee that he had observed that R55□s wheelchair had been tied to railing during the morning meal on 8/15/19. SSD informed the IDT of this during that mornings Stand-Up meeting which is also used as a means to discuss resident issues/concerns and QA matters. At this time the IDT reviewed the facility□s protocol for investigation of incidences of Abuse, Neglect and Exploitation as well as the flowchart for reporting (Incident Reporting for Alleged Abuse). Based on review of resident diagnosis, status, interview of staff, it was determined that there was no actual or potential for harm or willful intent to cause harm to the resident on the part of the Staff involved. As the receipt of the report of the incident was five (5) days post the incident occurring, and per staff interviews, there was no visual physical injury to the resident, no signs of mental abuse and no change in the residents affect and demeanor, the IDT determined that a report to the Survey Agency was not required. Therefore, no report was submitted at that time.	

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4 133	Continued From page 11 facility had discussed the issue, but determined that there was no actual harm, and thus, no further investigation was done. During a second interview with the Admin on 08/30/19 at 12:30 PM, Admin acknowledged that a potential for harm existed; thus, a thorough abuse investigation should have been initiated and reported to other officials (including the State Survey Agency). A review of facility policy titled Resident's Rights, Freedom from Abuse, Neglect, and Exploitation stated the following: Policy; Nuuanu Hale shall assure that all residents are fully aware of and able to exercise their rights during their stay at this facility and are treated by staff members, family members, friends, visitors and other residents in accordance with the rights to which they are entitled under applicable Federal and State regulations. Procedure for Investigation of allegations of abuse, neglect, exploitation or mistreatment; An investigation is immediately conducted when there are allegations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property and shall be immediately reported. 1. Allegations that involve abuse or result in serious bodily injury shall be reported immediately, but not later than 2 hours after the allegation is made. 2. Allegations that do not involve abuse and do not result in serious bodily injury shall be reported no later than 24 hours. 3. The Administrator or designee shall be notified immediately, who will immediately initiate the reporting to the Office of Health Care Assurance, Adult Protective Services and/or the Department of Human Services via the required reporting forms for each respective agency and as per above time frames. 4. An initial report will	4 133	A review of the facility Policy and Procedure was conducted and also the process for incident investigation was conducted with IDT. Based on the review, a report to the State Agency was completed and submitted. (9/3/2019) To prevent this deficient practice from recurring, all incidences of allegation of abuse, neglect and exploitation of resident property will be submitted to the State Agency and APS to ensure compliance with this requirement, as applicable. (9/3/2019 & ongoing) Ongoing monitoring and evaluation will be conducted by IDT and Administrator to ensure compliance with this requirement and discussed/addressed in quarterly QAPI/QAA as well as weekly Stand-up meetings as applicable. (9/3/2019 & ongoing)	

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4 133	Continued From page 12 be initiated with a final report submitted within 5 days. If the investigation is not able to be completed, an interim report shall be submitted providing the agencies with a revised time frame for submittal of final investigative report.	4 133		
4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: Based on observations, interviews, and review of policy, and record review, the facility failed to ensure there was sufficient nursing staff to assist four Resident's (R48, R47, and R7) in maintaining their highest practicable level of physical, mental, functional and psycho-social well-being. Also, the facility failed to ensure 1 (Resident 48) of 5 residents in the sample was free of accident hazards (aspiration) while feeding a resident with a diagnosis of dysphagia. Findings Include:	4 136	Nuuanu Hale is committed to ensure that sufficient and competent nursing staff is available to ensure quality care and services for residents under our care. Review of staffing schedule was conducted to identify and determine if staffing was sufficient to meet the acuity of the residents. It was determined that there were 4 licensed nurses for day, 4 for evening and 2 for night shifts; 6-8-day, 5 evening and 4 night shift direct care staff	10/8/19

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4 136	Continued From page 13 1. On 08/26/19 at 11:27 AM observed dining on the Pali unit hallway. A lunch tray was set-up for R48 on an overbed table, and registered nurse (RN) 12 proceeded to feed R48 a spoonful of rice mixed with pureed food. Before R48 finished swallowing the spoonful of food, RN12 walked into room 206, and assisted R26 into the hallway to set-up that resident with a lunch tray. While RN12 was assisting R26, R48 began to cough while trying to swallow the spoonful of rice and pureed food mixture. Within a few minutes RN12 returned to R48 with a syringe, and filled it with pureed food and mashed potatoes. While attempting to feed R48 by syringe filled with pureed food, RN12 also provided cues to another resident eating in the hallway. Then a staff member called for assistance from room 204, and RN12 put down the syringe and went to provide assistance. The R48 was left unsupervised again, as R12 helped and provided assistance to other residents on the unit. 2. On 08/29/19 at 12:02 PM during an interview with the Resident Council, three residents (R47, R7, Anonymous) stated that sometimes it takes between 30-45 minutes for staff to respond when pressing the call bell. They also stated that it usually happens when there is a shortage of staff. A review of facility policy titled Nursing Services revealed the following: Procedures, General Care, 1. Provides total nursing care including restorative nursing measures to the resident and coordiante nursing service with other resident care services directed toward assisting the resident to achieve and maintain his optimum level of self-care and independence. 3) A confidential resident interview was	4 136	with 1 Nursing Support Assistant for the day shift for the period of 8/26/19 to 9/3/19 when the facility had 70 residents. Residents were queried as to concerns of long wait periods for response to call lights. Residents indicated that the response to the call light was immediate as the Nursing Support Assistant (NSA) responded promptly and if the concern was not related to care issues, then the matter was handled immediately. However, if the matter was relating to care, then the wait period was extended as the NSA is not able to provide direct care. (9/3-12/19) To prevent recurrence of this deficient practice the following has been instituted: (9/4/19 & ongoing) 1. Ward Clerk position (recruitment began June 2019) is being actively recruited for. This position will assist in clerical audits of charts, monitor the nursing station and assist in directing inquiries. 2. We have been recruiting staff and were able to successfully hire: " 1 RN FTE and 1RN on call " 1 CNA FTE " 1 PT NSA for days/evening on weekends 3. We are continuing to recruit staff to ensure sufficient staffing 4. New staff Orientation Handbook was developed in Aug 2019 to ensure consistent training which has proven to be well received. 5. A new meal schedule has been developed and implemented for the delivery of resident meals based on	

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4 136	Continued From page 14 conducted on 08/27/19 at 07:45 AM. The resident was asked whether he/she is continent of bowel and bladder. The resident responded having awareness to urinate or defecate, pressing the call light and experiencing incontinence as care is not received in a timely manner. The resident commented that shi-shi (urine) and dodo (feces) does not wait and also stated who would want to to wipe you, so everybody disappears. A brief record review of the Minimum Data Set found this resident is cognitively intact and requires extensive assistance with one person physical assist for toilet use. This resident did not have a trial of a toileting program and coded as frequently incontinent of bladder and bowel. 4) Cross Reference to F656. Resident (R)48 was admitted to the facility on 04/04/16. Diagnoses include: acute posthemorrhagic anemia; Alzheimer's disease, unspecified; dysphagia; gastrointestinal hemorrhage, unspecified; metabolic encephalopathy; pneumonitis due to inhalation of food and vomit; and chronic atrial fibrillation. On 08/26/19 at 11:16 AM, R48 was observed during lunch meal with assistance from Registered Nurse (RN)12. RN12 was observed to scoop a spoonful of rice with pureed meat and placed the food in R48's mouth. R48 did not swallow the food, RN12 left R48 and entered Room 206. While in Room 206, R48 was observed to cough as she was trying to swallow the food. RN12 returned and scooped a spoonful of mashed potatoes onto the spoon. RN12 then used a syringe to continue feeding R48, RN12 attempted to coax R48 to open her mouth, but	4 136	resident preference and needs for staggering of meal delivery ensuring that staff will be able to provide assistance as required. 6. Application for approval to implement a Feeding Assistant Program through the Department of Human Services will be submitted before the end of the year, as this has been in the planning stages since 2018. 7. Staff will do more frequent rounding to ensure that residents needs are addressed timely. 8. Residents that are usually continent become incontinent will be assessed and placed on a Bowel and Bladder training program. Huddles were conducted with staff regarding the importance of: (9/3-4/19 & ongoing) 1. Communicating with one other when in need of assistance and to work as a team during the provision of resident care and meal service; 2. Ensure that all care tasks are completed before leaving a resident during meal service/feeding; 3. Call lights are responded to timely by any staff including Ward Clerk, NSA, Licensed Nurses and CNAs and addressed accordingly. Re-training of all staff on importance of teamwork, ongoing communication, timely provision of care, reporting of observations and use of Stop and Watch including reporting to Licensed Staff. (9/12-20/2019 & ongoing)	

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4 136	Continued From page 15 R48 did not open her mouth. RN12 then used the tip of the syringe to pry open R48's mouth and expel food into her mouth (left side). On 08/29/19 at 11:25 AM, R48 was observed in the hall with Certified Nurse Aide (CNA)11 assisting with the meal. R48's food was pureed and liquid thickened. CNA11 already filled the syringe with food. CNA11 alerted the resident by calling her name and rubbing her arm, R48 opened her mouth and CNA11 expelled food into the resident's mouth. CNA11 repeated this process, R48 was not choking or coughing. On 08/29/19 at 02:42 PM an interview was conducted with CNA11. CNA11 reported she expels 2 to 5 cc's of food at a time so R48 does not cough. CNA11 also reported trying to spoon-feed R48 but if she bites down on the spoon, the syringe is used. CNA11 states it takes approximately 20 minutes to feed R48 by syringe. Further queried whether the facility provided training on syringe feeding, CNA11 responded training was not provided. A review of R48's quarterly Minimum Data Set with assessment reference date of 07/01/19 documents R48 is severely impaired for cognitive skills for daily decision making. Also noted R48 is totally dependent on staff with one person physical assist for eating. On 08/29/19 at 01:43 PM, the facility provided a copy of R48's plan of care. A review of R48's care plan found no documentation that a care plan was developed for feeding R48. Further record review found a physician's order which included the following: feeding - syringe with puree solids and nectar liquids; and diet - regular pureed solids and nectar liquids.	4 136	Training of all staff will be conducted to ensure all are informed of the Plan of Correction and expectations of staff. (10/1-8/19) Ongoing monitoring and evaluation will be conducted by QA RN, DON Admin to ensure compliance with this requirement and discussed/addressed in quarterly QAPI/QAA as well as weekly Stand-up meetings as applicable. (9/3/2019 & ongoing) Nuuanu Hale is committed to ensure that residents are adequately supervised and assisted to prevent accidents. R48- Plan of Care was reviewed and revised to address the need for staff to remain with resident during meals to assure that resident will be monitored while eating to prevent choking and/or aspiration, when spoon feeding would be provided vs syringe feeding, quantity to provide the resident with the syringe feeding and what signs/symptoms to monitor for. Family members have opted to feed resident with a spoon as they are able to encourage resident to open her mouth during meals. (9/3/2019) Charts for all residents that are at risk for aspiration/choking were reviewed and revised as applicable to address the importance of monitoring residents and assuring their safety. (9/3-9/19) Development of Protocol for syringe feeding was conducted to address monitoring of residents during feeding to	

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4 136	Continued From page 16 A review of the initial Speech Therapist (ST) evaluation dated (10/05/18) notes R48 demonstrates oral stage dysphagia characterized by the inability to open her mouth. The resident also noted to bite on the spoon creating anterior spillage and delayed oral transit. The recommendation was to feed R48 with a syringe as the inability to open her mouth is the result of motor coordination and not behavioral refusal of PO intake. The ST discharge summary for date of service 10/05/18 to 10/22/18 documents R48 is fed via syringe with no overt signs and symptoms of aspiration. Delayed pharyngeal state noted. On 08/29/19 at 02:14 PM concurrent record review and interview was done with Director of Nursing (DON)1. DON1 confirmed there is no care plan for R48's feeding. DON1 reported the syringe may be used for meals and med pass. Inquired how are staff supposed to use the syringe (how much food to expel), is a trial of spoon feeding done first, who can feed the resident and is training required for feeding R48 via the syringe. DON1 reported the RN should feed the resident and maybe give the resident 25 cc of food at one time. The DON was not sure if training was required for syringe feeding.	4 136	ensure that process is correct and adhered to and ensure that resident□s dignity is assured. (9/18/2019) Retraining was provided to all licensed and direct care staff on the proper method for syringe feeding to ensure safety of resident, appropriate amounts of food to be given, signs and symptoms to monitor for and cleaning of syringe. (9/25-27/19) Huddles were held with all direct care and Licensed staff regarding the need to remain with residents that are at risk for choking or aspiration when they are being fed to monitor the resident□s status and assure that the correct quantity and texture is being provided via syringe to prevent aspiration and/or choking. (9/3-4/19) Retraining of staff was conducted to review the process of syringe feeding and to ensure that resident□s dignity and privacy is maintained. (9/25-27/19) Training of all staff will be conducted to ensure all are informed of the Plan of Correction and expectations of staff. (10/1-8/2019) Ongoing monitoring and evaluation will be conducted by QA RN and DON to ensure compliance with this requirement and discussed/addressed in quarterly QAPI/QAA as well as weekly Stand-up meetings as applicable. (9/3/2019 & ongoing)	

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4 152	Continued From page 17	4 152		
4 152	11-94.1-39(e) Nursing services (e) There shall be a policies and procedures manual that is kept current and consistent with current nursing and medical practices and approved by the medical advisor or director and the person responsible for nursing procedures. The policies and procedures shall include but not be limited to: (1) Written procedures for personnel to follow in an emergency including: (A) Care of the resident; (B) Notification of the attending physician and other persons responsible for the resident; and (C) Arrangements for transportation, hospitalization, or other appropriate services; (2) All treatment and care provided relative to the resident's needs and requirements for documentation; and (3) Medication or drug administration procedures that clearly define drug administration process, documentation, and authorized This Statute is not met as evidenced by: Based on observation, review of the facility's policy and procedures, and interviews with staff, the facility failed to adhere to facility protocol regarding tube feeding for 1 Resident (R)224 of 2 residents. Findings include:	4 152	Nuuanu Hale is committed to ensure that all feeding bags are to be labeled appropriately to ensure that the correct bag is provided to the correct resident and that the feeding bag is disposed as per facility Policy and Procedure/protocol.	9/17/19

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4 152	Continued From page 18 1) On 08/26/19 at 12:53 PM, observed R224's gravity feeding bag was written as 08/21/19. Inquired with the Registered Nurse (RN)7 about the date on the label written as 08/21/19, RN 7 stated that it was written as 08/26/19 and RN7 had "bad handwriting", the date was supposed to read as 08/26/19 and proceeded to write over the 21st to change it to the 26th. RN7 stated the 11:00 PM- 07:00 AM shift usually replaces and labels the gravity feeding bag daily, but due to R224 resuming tube feeding RN7 wrote the label. A second observation on 08/27/19 at 07:51 AM, the label on the gravity feeding bag in use was not dated. A review on the facility's policy and procedure on 09/03/19 at 11:18 AM, indicated that the gravity feeding bag label should contain the date. Inquired with the Director of Nursing (DON)1 on 09/03/19 at 10:10 AM regarding the policy on the labeling of the Gravity feeding bag. DON1 was not sure whether the resident's name, date, and time was on the label, but did endorse that the gravity feeding bag is usually changed by the 11:00 PM- 07:00 AM shift daily.	4 152	Review and revision of Protocols entitled Tube Feedings was conducted to address the proper procedure for labeling and disposal of feeding bags. (9/17/2019) Huddles were held with all licensed and direct care staff regarding the importance of ensuring that all feeding bags are labeled appropriately to ensure that the following information is provided correct resident, correct time/frequency, correct amount to be provided and also date for use/disposal. (9/3-4/19) To prevent recurrence of this deficient practice: (9/4/2019 & ongoing) 1. Night shift staff was retrained on the importance of appropriately labeling and disposing the feeding bags clearly in print that can be easily read. 2. Charge Nurse for the day shift shall ensure that all feeding bags are appropriately labeled at the beginning of each shift. Should there be a discrepancy, CN shall inform Night Shift RN, QA RN and DON to assure that staff carry out this responsibility accordingly. Ongoing monitoring and evaluation will be conducted by QA RN and DON to ensure compliance with this requirement and discussed/addressed in quarterly QAPI/QAA as well as weekly Stand-up meetings as applicable. (9/3/2019 & ongoing)	
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared,	4 159		10/8/19

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4 159	Continued From page 19 distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on surveyor observations,interviews with the dietary staff and a review of the facility's policy and procedures the kitchen failed to follow proper sanitation to prevent the outbreak of food borne illness. Findings Include: 1. Observation on 08/29/2019 after food preparation, there was a rack full of drinking cups with approximately 9 cups right side up and filled with fluid from the dishwasher. Staff D7 confirmed that the cups should have been placed upside down in the sanitary rack to allow thorough sanitization. 2. Observation on 08/29/2019 at 10:00 AM, found towels in a bucket filled with a clear solution. D5 stated that the solution was chlorine bleach and water, the mix is 3 teaspoons of chlorine bleach and water. D7 stated the solution should be 100 parts per million (ppm). Inquired whether the chlorine solution was tested, D5 stated no. D5 tested the solution with Hydrion test strips, when D5 compared the strip with the color indicator and reported it was 100ppm. However, D7 confirmed	4 159	Nuuanu Hale is committed to ensure that food is stored, prepared and served under sanitary conditions. Training was conducted of all Food and Nutrition Services staff by CDM regarding the importance of: (9/3-4/19) 1. Maintaining appropriate sanitizer levels in solutions used to wipe/disinfect equipment, counters, etc.; 2. Use of a clean scooper each time there is a need to remove dry products from stock supply and place used scooper in dishwashing sink; 3. When articles are dropped on the floor or non-sanitary area, staff are to place the article in dishwashing sink and or for laundering to ensure that all prep and service areas are not contaminated; 4. Dishes, pot, pans, cups will be placed properly onto dishwashing racks to ensure that they are properly washed and sanitized. If any article is noted to have water pooled on or in article, staff is to remove and return to another dishwashing rack for appropriate sanitization.	

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4 159	Continued From page 20 the test strip indicated the solution was 10 ppm not 100 ppm. D7 stated chlorine solution needs to be 100ppm. 3. Observation of food preparation on 08/28/2019, D6 scooped powder from a container which was labeled powdered mashed potato with vitamin C and placed the scooper back into the container. On 08/30/2019 at 11:38 AM, D6 and D7 were asked to open the container and both D6 and D7 observed the scooper in the container. When inquired about the facility's practice regarding the scooper in the mash potato container, D7 and D6 responded the scooper should not have been in the container. 4. Observation on 08/29/2019, D5 picked an oven mitt off the floor, placed the oven mitt on the plating counter. D6 was plating lunch with disposable gloves on, D6 then put on the oven mitt that had fallen on the ground and used the oven mitt to open and remove food from the oven. After using the oven mitt, D6 placed the fallen oven mitt partially on the tray of soup bowls. D6 did not change disposable gloves and continued plating lunch wearing the same disposable gloves that were placed inside of the oven mitt. Review of the facility's policy and procedure on Hand washing and Food Safety states, "Wearing gloves is not a substitute for appropriate, effective, thorough and frequent hand washing. Hands should be washed before and after application and removal. Gloves must be intact and in good condition and changed appropriately to help reduce the spread of microorganism."	4 159	Review of Policy and procedure for Sanitization of equipment, utensils, dishes/pots/pans, etc. was reviewed and discussed with staff to ensure compliance. (9/3-4/19) Protocol was developed for proper preparation of sanitizing solution and documentation of acceptable level when solution is made. Staff was trained on protocol. (9/3/2019) To prevent this deficient practice from recurring, audits will be conducted of proper process for preparing sanitizing solution and testing, dishwashing process, process to ensure that staff practices safe and sanitary process during the handling, preparation and serving of all food on a quarterly basis by CDM Food and Nutrition Services Manager. (9/3/2019 & ongoing) Training of all staff will be conducted to ensure all are informed of the Plan of Correction and expectations of staff. (10/1-8/19) Ongoing monitoring and evaluation will be conducted by CDM through observations and by Administrator through review of all documentations on audits and observations conducted and discussed/addressed in quarterly QAPI/QAA as well as weekly Stand-up meetings as applicable. (9/3/2019 & ongoing)	

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4 174	Continued From page 21	4 174		
4 174	11-94.1-43(b) Interdisciplinary care process (b) An individualized, interdisciplinary overall plan of care shall be developed to address prioritized resident needs including nursing care, social work services, medical services, rehabilitative services, restorative care, preventative care, dietary or nutritional requirements, and resident/family education. This Statute is not met as evidenced by: Based on observations, record reviews and interviews with staff member, the facility failed to develop a comprehensive person-center care plan for 2 (Residents 48 and 224) of 17 care plans reviewed. Findings Include: 1. Cross Reference to F689. R48 receives feeding via syringe to prevent aspiration as recommended by the Speech Therapist and ordered by the physician. The record review found no documentation of a plan of care with interventions regarding how to feed R48 (how many cc's of food/liquid to expel at one time, is there a trial of spoon-feeding before using the syringe, signs and symptoms of aspiration) to ensure prevention of aspiration. 2. Cross Reference to F697. Based on an individualized assessment of R224, the facility failed to develop a care plan to ensure management of pain. The facillity did not develop non-pharmacological and pharmacological interventions for pain management.	4 174	Nuuanu Hale is committed to ensure to ensure that comprehensive care plans are developed for all residents that describe services to be provided to residents to attain or maintain the resident□s highest practicable physical, mental, psychosocial well-being. For R48 - Plan of Care was reviewed and revised on 9/3/2019, to include care and services to be provided to resident and ensure that staff will feed resident with the syringe as resident tends to not open her mouth completely and tends to attempt to bite the spoon, amount to be given to prevent aspiration and/or choking as well as to provide the syringe feeding in resident room to maintain resident dignity and privacy. Family members have opted to feed resident with a spoon as they are able to encourage resident to open her mouth during meals. (9/3/2019) R224 □ resident had 2 admissions 1st on 7/24/19 and 2nd 7/30/19 and discharged on 8/28/19. Resident presented with complaints of	10/8/19

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4 174	Continued From page 22	4 174	abdominal pain. Review of nursing notes and PRN follow-up was conducted on 8/29/19 and 8/30/19 and identified that pain medication was provided to resident as requested and nurses checked on resident within 30 minutes post administration of medication and noted that resident was not moaning or sleeping peacefully. In the PRN follow-up notes, documentation demonstrated that resident pain level was rated on a scale of 0-10 and noted prior to and after medication provided. Documents were provided to Surveyor on 9/3/2019 for review as requested. Review of MAR verified that the PCP orders did not clearly define parameters for use of pain medications. (9/3/2019) Charts for all residents that are at risk for aspiration/choking and on pain management medications were reviewed and revised as applicable. (9/3-9/2019) To prevent this deficient practice the following will be conducted: 1. Audits of Plans of Care will be conducted by MDS Coordinator and QA RN immediately after development of resident Plans of Care to assure that all identified issues/concerns are addressed, and if the resident had any feeding issues, clearly stipulate how, when, amount, consistency and where feeding is to be provided. 2. Reviews will also be conducted prior to and immediately following Plan of Care meetings.	

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4 174	Continued From page 23	4 174	3. When PCP orders are received the Licensed Nurse shall ensure that clearly defined parameters are indicated on the orders for all medications received especially if there is more than one medication ordered for any specific condition. i.e.: for pain medications the order should indicate - name of drug, dosage, frequency, indication for use and if for mild, moderate or severe pain when more than one drug is ordered. Note: mild pain is usually at the rate of 1 -3; moderate 4-6 and severe 7-10. 4. Revised Baseline Care Plan was implemented to ensure that all resident identified needs are promptly care planned and addressed. (9/13/2019) Huddles were held for all licensed staff regarding the importance of ensuring that comprehensive care plans need to be developed to ensure that residents receive the necessary care and services. (9/3-4/19) Training of all licensed staff will be conducted to ensure that Comprehensive Plans of Care are developed and revised as applicable, to address resident identified needs. (9/12-20/19) Training held with all direct care staff to ensure that all are knowledgeable/aware of the changes made to the Plans of Care for applicable residents. (9/12-20/19) Training of all staff will be conducted to ensure all are informed of the Plan of Correction and expectations of staff. (10/1-8/19)	

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4 174	Continued From page 24	4 174	Ongoing monitoring and evaluation will be conducted by MDS Coordinator, QA RN and DON to ensure compliance with this requirement and discussed/addressed in quarterly QAPI/QAA as well as weekly Stand-up meetings as applicable. (9/3/2019 & ongoing)	
4 175	11-94.1-43(c) Interdisciplinary care process (c) The overall plan of care shall be reviewed periodically by the interdisciplinary team to determine if goals have been met, if any changes are required to the overall plan of care, and as necessitated by changes in the resident's condition. This Statute is not met as evidenced by: Based on an interview, record reviews, and review of the facility's policy and procedure, the facility failed to revise Resident (R)7's care plan following an unwitnessed fall and reassess the effectiveness of current interventions. Findings include: 1) During an interview with R7 on morning of 08/27/19, R7 informed the surveyors of a recent fall. A progress note written on 07/27/19 at 22:39 by Registered Nurse (RN)7 documented R7 had an unwitnessed fall with no evidence of injury. Additionally, a progress note written on 07/26/19 at 10:41 AM by Minimum Data Set Coordinator (MDSC)4, reported that R7 has been showing some possible signs of worsening dementia with increased forgetfulness/confusion. A review of R7's Care Plan documented that the care plan	4 175	Nuuanu Hale is committed to ensure that all plans of care will be revised based on changes that occur with resident's status, in a timely manner. R7 □ Plan of care was reviewed and revised to update information on recent fall and additional measures/intervention to prevent future falls. (9/3/2019) Charts for all residents that are at risk for falls were reviewed and revised as applicable to ensure that interventions and measures for prevention as clearly outlined to prevent future falls. (9/3-9/19) To prevent this deficient practice from recurring audits of Plans of Care will be conducted by MDS Coordinator and QA	10/8/19

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4 175	Continued From page 25 Goal was implemented on 03/21/18 and remained unchanged. The "Approach" or interventions to achieve the Care Plan Goal was implemented/edited on 3/21/18; 3/22/18; and 11/22/18. There was no evidence to suggest that the facility evaluated any of the "Approaches" implemented or effectiveness after R7 fell on 07/27/19. In an interview with Director of Nursing (DON)1 on 08/29/19 at 02:04 PM, inquired about how the facility evaluated R7's care plan to address R7's recent fall and worsening dementia. DON1 reviewed R7's Electronic Medical Record (EMR) with surveyors and confirmed that none of the interventions were updated or edited since the fall and stated that the goals and interventions should have been reviewed. A review of the facility's policy and procedure for Nursing Services states, the plan of care will be reviewed, monitored, evaluated and revised as necessary by all disciplines involved in the care of the resident during the care planning meeting or more frequently as required.	4 175	RN immediately after development of resident Plans of Care and as changes in residents occur. Reviews will also be conducted prior to and immediately following Plan of Care meetings. (9/3/2019 & ongoing) Huddles were held for all licensed staff regarding the importance of ensuring that comprehensive plans of care need to be developed to ensure that residents receive the necessary care and services and the need for continuous review of facility Policy and Procedures. (9/3-4/19) Training of all licensed staff will be conducted to ensure that Comprehensive Plans of Care are developed to address resident identified needs and the importance of communicating this information to all staff to ensure implementation of interventions during provision of care. (9/12-20/19 & ongoing) Training held with all direct care staff to ensure that all are knowledgeable/aware of the changes made to the Plans of Care for applicable residents to assure proper implementation of interventions developed. (9/12-20/19 & ongoing) Training of all staff will be conducted to ensure all are informed of the Plan of Correction and expectations of staff. (10/1-8/19) Ongoing monitoring and evaluation will be conducted by MDS Coordinator, QA RN, and DON to ensure compliance with this requirement and discussed/addressed in	

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4 175	Continued From page 26	4 175	quarterly QAPI/QAA as well as weekly Stand-up meetings as applicable. (9/3/2019 & ongoing)	
4 176	1-94.1-43(d) Interdisciplinary care process (d) Implementation of the overall plan of care shall be documented in each resident's medical record. This Statute is not met as evidenced by: Based on observations, record review and interview with staff member, the facility failed to implement the activity care plan for 1(Resident 56) of 1 sampled residents. Findings include: Resident (R)56 was admitted to the facility on 07/28/10. Diagnoses include the following: cerebral infarction (7/28/2010); Alzheimer's disease, unspecified; dementia in other disease classified elsewhere without behavioral disturbance; hyperlipidemia, unspecified; dysphagia, unspecified; major depressive disorder, single episode, unspecified; seborrheic dermatitis, unspecified; other muscle spasm; elevated blood-pressure reading, without diagnosis of hypertension; essential (primary) hypertension; gastrostomy status; gastrostomy infection; contracture of muscle, unspecified lower leg; and contracture, left elbow. Observation on 08/27/19 at 10:19 AM found R56 asleep in bed and he opened his eyes when surveyor spoke to him. The television was not on and there was no music playing. Second observation on 08/28/19 at 01:21 PM found R56 was on contact isolation (requiring personal	4 176	Nuuanu Hale is committed to ensure to ensure that each resident will assure that an ongoing program to support the resident□s' choice preference relating to activities will be provided. R56 □ a review of plan of care was conducted and determined to meet the resident's preferences as voiced by resident's representative as resident is unable to verbalize. Revisions to plan of care were made to clearly indicate the that TV would be turned on upon awakening of resident, when father arrives for his daily visits and left on till resident's bedtime. Father and brother will be reminded not to turn TV off as is their usual practice at the end of their daily visits. It was also noted that when changes were made in the provision of activities for the resident it was not noted and/or revised on the care plan. (9/3/2019) Charts for all residents were reviewed and revised as applicable to address resident preference and choice relating to activities and assure that special requests are also identified and documented. (9/3-9/19)	10/8/19

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4 176	Continued From page 27 clothing protector and gloves when entering the resident's room), R56 was asleep, snoring with no television/radio on. Observations on 08/29/19 at 08:23 AM R56's eyes were open and at 11:32 AM R56 was receiving nutrition via g-tube. There was no television or radio on during these observations. On 08/30/19, R56 was observed laying in bed. A review of the annual Minimum Data Set with assessment reference date of 02/08/19 found in Section F. Preferences for Customary Routine and Activities, staff assessment was conducted. R56's preferences include receiving shower, receiving bath, family or significant other in involvement of care decision. There was no item checked for activity preference. On 09/03/19, the facility provided a copy of R56's care plan. The care plan identified the problem for the resident being at risk for social isolation and sensory deprivation (onset of care plan 11/08/18 with editing done on 08/28/19). The goal is for activity staff to encourage resident and work with nursing staff to participate on one group activity a week and activity staff to provide sensory stimulation room visits two times a week. Also included in the care plan were interventions to address R56's psychosocial well-being. The interventions included: 1:1 room visit by activity aides; continue family visits; continue to engage him in simple conversations during visits and care; continue to monitor for signs/symptoms of depression; provide gentle approach at all times; and refer to psychiatrist if indicated. On 09/03/19 at 09:06 AM, the facility provided a copy of R56's annual activity assessment (signed by the Activities Coordinator on 02/08/19). The activity preferences identified included: contact	4 176	Huddles were held for all licensed and activities staff regarding the importance of ensuring that comprehensive care plans need to be revised on a timely manner to ensure that residents receive the necessary care and services. (9/3-4/19) To prevent this deficient practice training of all licensed, direct care and activities staff are aware of the revisions made to the resident's plan of care and the importance of the provision of all interventions will be provided and appropriately documented. Also, should the resident be placed on isolation precautions, different modalities for the provision of activities may be needed to be developed and addressed in the resident's plan of care. (9/12-20/2019 & going) Training of all staff will be conducted to ensure all are informed of the Plan of Correction and expectations of staff. (10/1-8/19) Ongoing monitoring and evaluation will be conducted by Activities Director, QA RN and DON to ensure compliance with this requirement and discussed/addressed in quarterly QAPI/QAA as well as weekly Stand-up meetings as applicable. (9/3/2019 & ongoing)	

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4 176	Continued From page 28 with others, room visits, 1 on 1, small group, and noted R56 has strong family support with Father visiting every morning. Also noted, activity supply needed or relevant to activity involvement included TV/radio in room. The coordinator notes that "sensory stimulation is most effective for resident". A review of the Activity participation documentation found R56's care plan interventions for small group activity and sensory stimulation during room visits (two times a week) was not being implemented. There was no documentation of activity participation for the following weeks: 07/14/19 to 07/20/19; 07/21/19 to 07/27/19; 08/04/19 to 08/10/19; and 08/18/19 to 08/24/19. R56 received activity once a week for the following weeks between 06/30/19 to 08/31/19: 06/30/19 to 07/06/19; 07/07/19 to 07/13/19; 07/28/19 to 08/03/19; and 08/25/19 to 08/31/19. An interview was conducted with the Director of Nursing (DON)1 on the morning of 09/03/19. DON1 reported the Activities Coordinator is working part-time or on-call. A review of the documentation of R56's activity participation was done with the DON. The DON acknowledged activities were not being provided in accordance with the resident's care plan; however, reported the activity staff meet daily to discuss all the residents. Inquired whether activities were not provided due to R56's contact isolation status? DON1 was unable to provide documentation of the reason for not meeting R56's activity goal.	4 176		
4 199	11-94.1-46(p) Pharmaceutical services (p) When appropriateness of drugs or dosage of	4 199		10/8/19

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4 199	Continued From page 29 drugs as ordered are questioned by the pharmacist or licensed nurse, the licensed nurse or the pharmacist shall consult the physician, and a record of the consultation shall be made available to the administrator of the facility or director of nursing. This Statute is not met as evidenced by: Based on observation, record review, interview with staff member and resident representative, the facility failed to ensure pain management was provided to 1(Resident 224) of 3 residents in the sample. The facility failed to define parameters for use of medications and consistently manage pain. Findings Include: Cross Reference to F697. Resident (R)224 was admitted to the facility on 07/24/19. On 07/27/19, R224 was transferred to the hospital with gastrointestinal bleeding with anemia and returned to the facility on 07/30/19 at 03:32 PM. R224 diagnosis include: gastronomy; gastrointestinal hemorrhage; atherosclerosis heart disease of native coronary artery with unspecified angina pectoris; cerebral infarction; unspecified, muscle weakness; iron deficiency anemia secondary to blood loss (chronic); essential (primary) hypertension; diabetes; chronic kidney disease stage 3; paroxysmal atrial; aphasia; dysphasia following cerebral infraction; pain; and pneumonia. Observed R224 in bed moaning and waving his right hand in the air on 08/26/19 at 12:34 PM. R224 placed his hand on his abdomen and mumbled "sore". Inquired if R224 needed help,	4 199	Nuuanu Hale is committed to ensure that pain management is provided to residents based on their comprehensive assessment, plan of care and physician orders. R224 □ resident had 2 admissions 1st on 7/24/19 and 2nd 7/30/19 and discharged on 8/28/19. (9/3/2019) Resident presented with complaints of abdominal pain. Review of nursing notes and PRN follow-up was conducted on 8/29/19 and 8/30/19 and identified that pain medication was provided to resident as requested and nurses checked on resident within 30 minutes post administration of medication and noted that resident was not moaning or sleeping peacefully. In the PRN follow-up notes, documentation demonstrated that resident pain level was rated on a scale of 0-10 and noted prior to and after medication provided. Documents were provided to Surveyor on 9/3/2019 for review as requested. Review of MAR on 8/29-30/19 verified that the PCP orders did not clearly define parameters for use of pain medications. Charts for all residents that are on pain	

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4 199	Continued From page 30 R224 nodded head "yes". A resident representative interview was done on 08/26/19 at 01:00 PM with R224's wife and son, R224's wife reported that R224 has pain. A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date of 08/06/2019 assessed R224's cognitive skills for daily decision making as modified independence (some difficulty in new situations only). A review of R224's activities of daily living found R224 is totally dependent with 2 person assist for transfer and bathing; totally dependant with 1 person physical assist for toileting; requires extensive assistance with 1 person physical assist for personal hygiene; and R224 is limited assist with 2 person physical assist for bed mobility and dressing. R224 has bilateral upper and lower extremity limitation. In the Health Condition section of the MDS, J0100 notes no scheduled pain medication regime, received as needed (PRN) pain medication and no non-medication intervention with in the last 5 days. The staff assessment for pain was conducted, indicators of pain include non-verbal sounds, vocal complaints, and facial expressions. In the last 5 days, R224 exhibited indicators of pain or possible pain observed for 3 to 4 days. Review of the Care Area Assessment Summary documented R224 has "complaints of generalized pain per staff, he moans occasionally and sometimes can tell staff that he is in pain. He is on PRN Tylenol and Tramadol. He mostly stays in bed; per staff he moans even when he is not doing any activities and there has been occasion where sleep has been affected. Staff to continue to give him his pain medication as ordered and update the medical doctor for increasing pain or discomfort. Put him in the position of comfort. Will proceed with care plan with the goal that his	4 199	management medications were reviewed and revised to ensure that pain is consistently monitored and that parameters for medications are clearly defined in the physician orders. (9/3-9/2019) Huddles were held for all licensed staff regarding the importance of ensuring that residents on pain medications are monitored closely to determine efficacy of medications provided, document appropriately and consistently when medication is provided with follow-up evaluation conducted to assure of resident is comfortable and free from pain. (9/3-4/2019) To prevent this deficient practice, retraining was provided to all licensed staff on: (9/13/19) 1. When PCP orders are received the Licensed Nurse shall ensure that clearly defined parameters are indicated on the orders for all medications received especially if there is more than one medication ordered for any specific condition. i.e.: for pain medications the order should indicate - name of drug, dosage, frequency, indication for use and if for mild, moderate or severe pain when more than one drug is ordered. Note: mild pain is usually at the rate of 1-3; moderate 4-6 and severe 7-10. 2. Monitor and document in EMR nursing notes and PRN follow-up efficacy of medications 20 -30 minutes post administration and if not effective provide medication as ordered by PCP. 3. Document all follow-up action taken,	

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4 199	Continued From page 31 pain will be controlled while in the facility with the current regimen." Further review showed no documentation of pain management in the Care Plan. Review of the physician's order includes Acetaminophen Oral 650 mg/20.3 ml take 30.5 ml every 6 hours as needed for pain with a start date of 07/24/19; Tramadol 50 mg 1 tablet every 6 hours as needed for moderate to severe pain with a start date of 07/30/19; and assess for pain three times a day. The orders do not provide parameters for the distinguishing between the use of Acetaminophen or Tramadol. Which medication is used to treat mild pain versus severe. Also, are staff able to combine both PRN pain medication for relief of pain. In addition, the scale used by staff to rate and relay R224's level of pain is inconsistent. A progress note written on 07/25/19 by Licensed Practical Nurse (LPN)6 rated R224's pain level on a 1-10 pain scale, then documented the effectiveness of the PRN as "slight relief". Furthermore, a review of the Medication Administration Record (MAR) R224 received Acetaminophen Oral 650 mg 3 doses on 07/25/19 and 1 dose on 07/26/19. The August 2019 MAR documented R224 received 13 doses of Tramadol and no doses of Acetaminophen, there was no documentation of the time the medication was provided. Further review found staff members endorsed by initial that R224 was assessed for pain; however, there is limited record of the results of the assessment. Additionally, a progress note written on 08/20/19 documents a physician's order for an X-ray of the abdomen for continuous complaint of pain, however, R224 did not receive Tramadol or Acetaminophen from 08/16/19 through 08/26/19. Further review of the all documented progress notes provided by the facility found inconsistency	4 199	resident reaction to medication, and need to follow-up with PCP as applicable. 4. Revised Baseline Care Plan was implemented to ensure that all resident identified needs are promptly care planned and addressed. Training of all staff will be conducted to ensure all are informed of the Plan of Correction and expectations of staff. (10/1-8/19) Ongoing monitoring and evaluation will be conducted by MDS Coordinator, QA RN, and DON to ensure compliance with this requirement and discussed/addressed in quarterly QAPI/QAA as well as weekly Stand-up meetings as applicable. (9/3/2019 & ongoing)	

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4 199	Continued From page 32 of the evaluation of R224's pain levels, numeric pain level or other indicators (facial grimacing/moaning) were utilized. In an interview and concurrent review of the resident's record was done on 09/03/19 at 08:40 AM. DON1 confirmed the facility did not develop a plan of care to address the management of R224's pain. Inquired with DON1, regarding the administration times of the pain medication on MAR, DON1 reviewed the MAR and reported the MAR does not have documentation of the time the medication was administered. The DON also reported nursing staff should document in the progress notes if the pain subsided and if not they are to call the physician. Inquired whether the facility's system for monitoring R224's pain was effective. DON1 did not confirm effective management of the resident's pain.	4 199		
4 203	11-94.1-53(a) Infection control (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Statute is not met as evidenced by: Based on observations and interviews with staff members, the facility failed to ensure transmission-based precautions were followed to prevent the spread of infections during cleaning of room which was occupied by a resident on contact isolation precautions. The facility also failed to utilize hand hygiene procedures between	4 203	Nuuanu Hale is committed to ensure maintenance of a safe, sanitary and comfortable environment and to help prevent the development and spread of disease and infection. Housekeeping staff in question was	10/8/19

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4 203	Continued From page 33 residents. Findings Include: 1) Observation on 08/28/19 found Resident (R)56 was on contact precaution/isolation. The Certified Nurse Aide (CNA)34 instructed surveyor to wear a personal clothing protector and gloves when entering the resident's room. A record review on 08/29/19 at 07:35 AM found an infection control report which notes R56 has an infection to his g-tube site which was acquired in the facility. The symptoms included skin (swelling, redness-localized, drainage) with yellow purulent draining and light brown and greenish drainage. The culture (07/03/19) found pseudomonas, staphylococcus, and proteus mirabilis. Antibiotics (cipro, Bactrim, Augmentin and doxycycline) were provided. Also of note was the g-tube site was noted with four organisms: serratia marcescens (4+) which is sensitive to both cipro and sulfa; pseudomonas aeruginosa (1+) which is sensitive to cipro and levo; staph aureus "MRSA" (4+) and proteus mirabilis (1+) which is sensitive to sulfa and augmentin. A review of the physician's orders found the following: 05/21/19-05/28/19-Bactrim DS Oral tablet 800-160 mg, give twice daily for seven days due to GT site cellulitis; 07/08/19-07/22/19-Bactrim DS tablet 800-160 mg, one tablet for two weeks due to GT infection; and 08/06/19-08/12/19-Augmentin 500 mg. three times a day for seven days due to GT site infections. On 08/29/19 at 09:39 AM, Registered Nurse (RN)5 reported R56 is no longer on contact precaution.	4 203	retrained on the importance and purpose of use of PPE during contact isolation by Supervisor. (9/3/2019 & ongoing) Huddles held with all housekeeping, maintenance, activities, direct care and licensed staff regarding the proper use of PPE and importance and purpose of PPE use as related to contact isolation. (9/3-4/19) To prevent this deficient practice from recurring: (9/3/2019 & ongoing) 1. Audits of staff competency in adherence to infection control practices especially as relating to appropriate use of PPE and appropriate hand washing to be conducted by QA RN and documented. 2. Annual retraining of all staff on appropriate use of PPE, appropriate hand washing and competency to be documented. 3. System/process to ensure that effective communication is done when residents are placed and/or removed from isolation, and when PPE use is no longer required. Training of all staff will be conducted to ensure all are informed of the Plan of Correction and expectations of staff. (10/1-8/19) Ongoing monitoring and evaluation will be conducted by QA RN, IP and DON to ensure compliance with this requirement and discussed/addressed in quarterly QAPI/QAA as well as weekly Stand-up meetings as applicable. (9/3/2019 & ongoing)	

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4 203	Continued From page 34 Observation on 08/29/19 at 09:45 AM found Housekeeper (HSKP)7 cleaning Room 118. R56 was on contact isolation for MRSA. The housekeeper was wearing blue gloves, removed the lid of the sanitizing cloth container (gold top) which was placed on a stand outside of the resident's room. The housekeeper entered the room and began to wipe down the outside of the two black trash bins at the entrance to the room. HSKP7 did not remove gloves and removed more wipes from the container. The housekeeper proceeded to wipe the inside of the trash bins, under the bins and the lid pedal. HSKP7 did not remove gloves, exited the room and covered the sanitizing cloth container. HSKP7 removed the gloves and used hand sanitizer. The housekeeper was then observed to roll out a bedside tray and place a roll of trash liners and tape dispenser atop the bedside tray. HSKP7 donned gloves and removed a trash liner and placed one of the trash bins into the liner. The liner was taped to the top. The second trash bin was placed in a liner and taped at the top. The housekeeper exited the room and used a sanitizing cloth to wipe the signage then proceeded to wipe the top, side and inside the cart. While holding the used sanitizing cloths in his/her hand, closed the top of the dispenser. The used sanitizing cloth was thrown in the rubbish can in Room 116. The sanitizing cloth dispenser, roll of trash liners and tape dispenser were placed in the nurse station. HSKP7 removed the gloves and threw the used gloves into Room 116. HSKP7 donned gloves, returned to the room and carried the two trash bins outside and placed the bins in front of a closed door. HSKP7 reported maintenance will	4 203		

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4 203	Continued From page 35 be called to get the bins for cleaning. On 08/29/19 at 10:00 AM an interview was conducted with Director of Nursing (DON)2. The observation of the cleaning of the trash bins was shared with DON2. The DON acknowledged infection control breeches when the housekeeper wiped down the trash bins, did not removed gloves and covered the sanitizing cloth container. DON2 reported the used gloves and sanitizing cloths should not be thrown into another resident's room. DON2 also reported the HSKP7 should have wiped down the roll of trash liners and tape dispenser before returning it to the nursing station. DON2 was agreeable agreed to follow-up whether HSKP7 needed to wear a personal clothing protector while cleaning the trash bins. On 08/29/19 at 02:09 PM an interview was conducted with DON1. Inquired whether the housekeeper is required to wear a clothing protector while cleaning the trash bin. DON1 replied if HSKP7's clothing doesn't touch or is in contact with the trash bin, a clothing protector is not required. DON1 acknowledged the whole role of trash liners should not have been taken into the room, the housekeeper should have taken only the amount of liners required. 2. Observation on 08/26/2019 at 10:40 AM in the 1st floor dining room, Activities Staff (AS)5 was wearing blue disposable gloves and handing out individual cleaning wipes to residents. AS5 approached Resident (R)22, opened the individual cleaning wipe, removed the wipe, and proceeded assist R22 with wiping of hands. AS5 assisted R22 by utilizing hand-over-hand method. AS5 did not remove or change disposable glove or perform hand sanitization/hand washing and	4 203		

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4 203	Continued From page 36 proceeded assist R34. AS5 assisted R34 with opening the cleaning wipe packet then proceeded to assist R34 with hand-over-hand method of cleaning. At 10:45 AM, AS5 was interviewed and stated that disposable gloves should be changed between assisting residents with hand hygiene.	4 203		
4 243	11-94.1-64(a) Engineering and maintenance (a) The facility shall maintain all essential mechanical, electrical, and resident care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations and staff interview, the facility failed to secure the Biohazard room located on the Ewa nursing unit. As a result of this deficient practice, the facility put the safety and well-being of the residents as well as the public at risk for accident hazards. Findings Include: During an observation of the Biohazard room (located on the Ewa nursing unit) on 08/28/19 at 10:40 AM, it was noted that the door to enter the room was not secured and anyone could have entered the room freely. There was also no staff in the immediate vicinity to prevent anyone from entering the room. The room contained two trash containers with Biohazard waste material, and two plastic containers labeled Rx Destroyer, Pharmaceutical Disposal. Any of these items could have put the safety of the residents and the public at risk for accident hazards. During the above observation, Housekeeper (HSKP) 10 was queried about the room not being secured. HSKP 10 acknowledged that the door	4 243	Nuuanu Hale is committed to ensure the facility including the physical environment, equipment, etc., are maintained to ensure the safety of residents, personnel and the public. The latch to the Biohazard Room door was confirmed to be difficult to latch and was repaired by Maintenance. (9/17/2019) To prevent recurrence of this deficiency the following has been implemented: (9/4/2019 & ongoing) 1. Each staff member when closing the door Biohazard Door will inform the Charge Nurse, who will complete a work order and submit to Maintenance Tech for repair; 2. Upon receipt of work order, Maintenance Tech will immediately repair the faulty lock/latch, 3. Maintenance Tech will check on door lock/latch monthly as part of the monthly Preventive Maintenance Schedule to	9/17/19

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4 243	Continued From page 37 should have been locked and the room secured. HSKP 10 also acknowledged that when closing the door, you would have to close it forcefully in order for the lock to latch on.	4 243	ensure good working order. Ongoing monitoring and evaluation will be conducted by Maintenance Supervisor to ensure compliance with this requirement and discussed/addressed in quarterly QAPI/QAA as well as weekly Stand-up meetings as applicable. (9/3/2019 & ongoing)	